

EXPERIENCES OF WOMEN WITH DEPRESSION ON REHABILITATION
COUNSELLING IN MKUSHI DISTRICT OF ZAMBIA

BY

NAMASIKU SAMASUMO KASONGO

A Dissertation submitted to the University of Zambia in Collaboration with Zimbabwe Open University in partial fulfillment of the requirements for the award of the degree of Master of Science in Counselling

UNZA-ZOU@2020

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DECLARATION

I, NAMASIKU SAMASUMO KASONGO, do hereby declare that this dissertation is a product of my own effort, and sources of all materials referred to in this report have been acknowledged. This research project is my original work and has not been presented for a degree award in any other university.

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Signature

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Date

APPROVAL

I, the undersigned, hereby certify that I have read the dissertation and find it to be in a form acceptable for examination in fulfillment of the requirement for the degree of Master of Science in Counseling of the University of Zambia.

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DEDICATION

To my husband, Emmanuel, for being the greatest support I could have asked for.

ACKNOWLEDGEMENTS

Special thanks go to my husband for his unwavering support rendered to me during the duration of this study.

Special thanks also go to my children who endured many months of my unavailability, and who were understanding, loving and supportive toward my work.

Special thanks go to my supervisor, Dr. Daniel Ndhlovu, for his guidance, for keeping me accountable and for encouraging me to finish strong.

Special thanks go to my mum, my children and friends, for cheering me on as I worked on this study.

Special thanks also go to my classmates/colleagues, for their encouragement and moral support during this study.

ABSTRACT

The prevalence of Depression has been on the increase among Zambians (Munakampe, 2020) hence the need for rehabilitation counselling. What is not known is how rehabilitation counselling helped women who had depression in Mkushi District. It is from this perspective that this study sought to explore experiences of women who had depression in Mkushi district in terms of how rehabilitation counselling helped them. The Cognitive Behavioural Theory guided this study. Eight women with depression were selected using criterion sampling with depression as the criterion of importance, to take part in an interpretive phenomenological study aimed at exploring the experiences of women with depression on rehabilitation counselling in Mkushi District of Zambia. They were interviewed and their responses thematically analyzed.

Findings showed that causes of depression among women in Mkushi were marital problems, chronic illness, lack of income, illnesses such as HIV/AIDS, abuse, infertility, and the inability to care for family; that most women in Mkushi have never experienced rehabilitation counselling for their depression; that a lack of knowledge about causes, symptoms and treatment was a hindrance to accessing depression rehabilitation counselling among women in Mkushi District, and that information about depression (causes, symptoms, treatment) so that people have an idea exactly what to do and where to go for help, was needed. In addition, there was need for rehabilitation counselling to be introduced at primary care level.

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CHAPTER ONE: INTRODUCTION

1.0 Overview

This chapter presents the background of the study, statement of the problem, purpose of the study, research objectives, research questions, significance of the study, the conceptual framework, delimitation and limitations of the study and definitions of key terms.

1.1 Background

Depression is the most commonly diagnosed mental disorder in the health sector (WHO, 2020). At a global level, over 300 million people are estimated to suffer from depression, equivalent to 4.4% of the world's population (WHO, 2017). More women are affected by depression than men (WHO, 2017, Otte et al, 2016). Rehabilitation counselling has been reported to help people who suffer from depression (iResearchnet.com, 2021). There is need therefore to establish how rehabilitation counselling helped women with depression in Mkushi district of Zambia.

The prevalence of Depression is on the increase among Zambian women. There is very little research to substantiate why this increase is apparent in Zambia. Whether the increase is due to an actual rise in prevalence rates, or just a rise in awareness and diagnosis of the disorder, is still to be determined. One thing that is clear though, is that diagnosed cases of depression have been on the rise among women in Zambia.

Also called Major Depressive Disorder or Clinical Depression, depression is a mood disorder that causes a persistent feeling of sadness and loss of interest in life. Major depressive disorder (MDD) is a debilitating disease that is characterized by depressed mood, diminished interests, impaired cognitive function and vegetative symptoms, such as disturbed sleep or appetite (Otte et. al. 2016). One may have trouble doing normal day-to-day activities, and sometimes may feel as if life is not worth living. More than just a bout of the blues, depression is not a weakness or a feeling of sadness and one cannot simply "snap out" of it.

There are many varied causes of depression. Upsetting, stressful or traumatic life events, such as bereavement, divorce, illness, loss of a job etc. can cause depression. People with certain personality traits, such as low self-esteem, are more prone to depression. Sometimes depression runs in the family. Loneliness caused by things such as becoming cut off from one's family and

friends can also increase one's risk of depression. Amongst women, hormonal and physical changes as a result of pregnancy can also cause depression. A study aimed at determining the levels of depression among HIV patients in Zambia found that one of the major causes of depression among women is due to testing positive for the Human Immunodeficiency Virus, HIV (Paul, Maila and Thankian, 2019).

Depression manifests through psychological, physical and social symptoms. Some psychological symptoms are things like a continuous low mood, feeling hopeless and helpless, having low self-esteem, having no motivation or interest in one's normal routines etc. Some physical symptoms may include lack of energy, moving or speaking more slowly than usual, a low sex drive, difficulty sleeping, changes in appetite or weight and many others. Social symptoms are the most telling and could include avoiding contact with friends, taking part in fewer social activities, neglecting one's hobbies and interests and more often than not, having difficulties functioning at home, at work or in their family life.

Untreated, depression can lead to the likelihood of one engaging in high risky sexual behaviour, substance abuse, not keeping medical appointments and not adhering to medications. Untreated, depression can lead to a fatal consequence, suicide.

Many live miserably with depression. Top on the list of reasons for this is stigma. Seeking treatment for depression is something one avoids because they are ashamed of the mental illness. The stigma surrounding mental health treatment prevents thousands of people from getting the assistance they need every year. The cultural connotations of having a mental illness are brutal. In African tradition, there is only one word for the many types of mental illness, "madness" which is so abhorrent and embarrassing to a family that hiding the illness is not even questioned, it is expected.

Another reason people live with depression has to do with the setup of the health system in the country. Firstly, the country does not seem to have adequate visible mental health practitioners in the health institutions. Where these are present, the general populace seems to have no idea how and where to access their services. Secondly, diagnosis and treatment at primary health care facilities seems to be virtually non-existent. People go undiagnosed and untreated. Thirdly, at primary health care level such as local clinics, there are lower qualified counsellors who may not be very well equipped in rehabilitation counselling and mostly trained for Voluntary Counselling

and testing, VCT for the Human Immuno-Deficiency Virus, HIV. These end up referring clients to higher health institutions which are already swamped with massive numbers of people seeking help. In a semi-rural area like Mkushi, the clients get referred to Kabwe or Lusaka where the main hospitals are. Fourthly, compounding the situation is the assertion that funding for the available public mental institutions is low and unsustainable. Fifthly, health facilities that happen to offer optimal mental health services are private and expensive, out of the reach of the average Zambian. The majority of Zambians do not have medical insurance to cover bills. Lastly, mental health drugs such as anti-depressants are very pricey and unaffordable to most.

Depression is a mood disorder whose prevalence rate is on the rise among young women in Zambia. There are several causes of depression among women but the major one so far, is due to testing positive for the Human Immuno-Deficiency Virus, HIV (Paul, 2017). Untreated, depression can lead to suicide, dysfunctionality in school, at home and at work, the likelihood of engaging in high risk sexual behaviour, substance abuse, not keeping medical appointments and not adhering to medications. What is not known is how rehabilitation counselling helped the women who had depression in Mkushi District. There is need therefore, to explore experiences of women who had depression in Mkushi district in terms of how rehabilitation counselling helped them.

1.2 Statement of the Problem

The list of hindrances to treatment of not just depression but other mental illnesses is not just long, but rather imposing. But people with depression cannot recover from it all on their own. Their situation is even worsened if it exists in conjunction with an alcohol or a drug abuse problem as some people have turned to such substances to manage their depression. One thing that is outstanding is that they need rehabilitation counselling especially if the prevalence rate of depression continues to rise. This is supported by Khan and Khan (2012) who found that this can bring resolution to depression in women. What is not known is how rehabilitation counselling helped the women who had depression in Mkushi District. There is need therefore, to explore experiences of women who had depression in Mkushi district in terms of how rehabilitation counselling helped them.

1.3 Purpose of the Study

The purpose of the study was to explore the experiences of women with depression on rehabilitation counselling in Mkushi District.

1.4 Study Objectives

- i. To establish the causes of depression among young women in Mkushi District.
- ii. To explore experiences of how rehabilitation counselling helped women with depression in Mkushi District.
- iii. To identify major hindrances if any, to accessing depression rehabilitation counselling among women in Mkushi District.
- iv. To suggest measures on how to make Depression Rehabilitation Counselling services easier to access.

1.5 Research Questions

- i. What are the causes of depression among women in Mkushi District?
- ii. What are the experiences of how rehabilitation counselling helped women with depression in Mkushi?
- iii. What are the major hindrances if any, to accessing depression rehabilitation counselling among women in Mkushi District?
- iv. What measures could make accessing Rehabilitation Counselling services easier for women in Mkushi District?

1.6 Limitations of the Study

Since this is a qualitative study, its results could not be generalised. In addition, interpretative phenomenological design used 8 as a sample size which does not warrant generalisation.

1.7 Significance of the Study

The rise in the prevalence rates of depression among young women translates into a dysfunctional cohort of the Zambian population that are supposed to make a significant contribution to the general stability and development of society at all its social levels; the home, the marketplace/corporate world, the business world and even government. Experiences of women with Depression in Mkushi, who were helped with Rehabilitation Counselling, are useful

in giving a clearer picture of the situation on the ground. These experiences are also useful for exploring what needs further attention in order to make accessing this service easier and helpful to other women with Depression in Zambia, especially in rural areas. This study is therefore important in that:

- a. It explored how the experiences of depressed women in Mkushi illuminated the situation prevalent on the ground.
- b. It explored what the causes of the rising prevalence rates of depression among women in Mkushi were to better prepare counsellors for appropriate intervention measures.
- c. It explored what rehabilitation counselling services and service providers were available to women with depression in Mkushi.
- d. It contributed much needed information about how to overcome hindrances of access to rehabilitation counselling.
- e. It contributed first-hand information from the affected about how to make access to rehabilitation counselling services easier at primary health care level.
- f. It amplified the voices of women affected by depression to the various stakeholders that can aid the access to rehabilitation counselling in Zambia.

1.8 Scope of the study

This study was focused on women with depression in Mkushi District. Mkushi district was chosen as a site because it was easy to access these women. Mkushi was also conveniently located to the researcher.

1.9 Theoretical Framework

The Cognitive Behavioural Theory, by Aaron T. Beck guided this study. It is an approach that counsellors use to help clients deal with problems relating to cognitive behaviour. According to Sarmah (2021), Beck advances that “if beliefs do not change, there is no improvement. If beliefs change, symptoms change. Beliefs function as little operational units...” This implies that dysfunctional behaviour is brought about by dysfunctional thinking, that thinking is shaped by one’s beliefs, and that one’s beliefs decide the course of their actions. On the basis of this

theory, a therapy called Cognitive Behavioural Therapy was developed to effectively treat depression and other disorders.

Cognitive Behavioural Therapy (CBT) is a mixed methods approach to Rehabilitation Counselling, which is a specific practice of counselling where counsellors work to help people who have mental, emotional and physical disabilities so that they are able to live more independently. CBT is based on the premise that the way one behaves and thinks affects the way they feel, i.e., people with depression tend to have self-defeating thoughts that can lead to negative behaviour. CBT aims to help them identify and address these negative thoughts and replace them with more wholesome thoughts that help manage their depression.

The Behavioural component of CBT was explored in relation to the women in Mkushi because this approach views depression as resulting from a person's interaction with their environment. The Cognitive component was explored because this approach views Depression as resulting from systematic negative bias in thinking processes. CBT focuses on recognizing and changing thought patterns and behaviours that lead to troublesome feelings and actions. It helps limit distorted and false thinking by looking at concerns more realistically. With Rehabilitation Counselling, the ultimate goal was to explore whether CBT was used to teach the Mkushi women to live fruitful lives that are wholesome, meaningful and productive so they can function normally in their lives again.

1.10 Definition of Key Terms

- a. Rehabilitation Counselling: a systematic talk therapy which assists persons with depression learn and begin to functioning normally at home, at work or in their family life.
- b. Cognitive Behavioural Therapy: A mixed methods approach (from Cognitive and Behavioural Theories of Psychology) to Rehabilitation Counselling.
- c. Depression: A mood disorder that causes dysfunctionality in a person's emotional, social and physical lives, rendering unable to cope with their life.

CHAPTER TWO: LITERATURE REVIEW

2.0 Overview

This chapter presents literature relevant to this study. It is divided into five sections. The first section is dealing with rehabilitation counselling for women with depression. The next four are each dealing with one of four research objectives of this study. These are: Causes of Depression Among Women; Experiences of Rehabilitation Counselling for Women; Hindrances to Rehabilitation Counselling for Women, and Measures to Make Access to Rehabilitation Counselling Services Easy for Women.

2.1 Rehabilitation Counselling for Depression

Human beings have a psychological need for continuous personal growth and development to find meaning and purpose in their lives. Each person has their own definition and description of what this looks like. For women, this ranges from successful careers, to financial independence, to marriage and children etc. When these markers of success are threatened or eliminated, by either environmental or social or biological or even lifestyle factors, women become distressed and their lives dysfunctional, necessitating the need for rehabilitation counselling. This counselling is done in a bid to help them recover from a difficult period in their life. At the end of successful rehabilitation, a woman should have the same abilities she had originally, but with the knowledge empowering her to cope better should the same problems arise again in her future.

A Psychology Research and Reference online platform defines rehabilitation counselling as

a systematic process which assists persons with physical, mental, developmental, cognitive and emotional disabilities to achieve their personal, career and independent living goals in the most integrated setting possible through the application of the counselling process. The counselling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social and behavioural interventions (iResearchnet.com, 2021).

Treating depression using rehabilitation counselling, from the above definition, encompasses an eclectic mix of talk therapy either individually or in a group, lifestyle changes like getting enough sleep, exercise and good nutrition etc., called Cognitive Behavioural Therapy, CBT. In

particularly bad cases of depression, the use of medications is the first line of defence to get the depression to levels where talk therapy and lifestyle changes are possible.

Zhang et. al. (2018) assert that Cognitive Behavioural Therapy (CBT) is one of the most frequently used psychosocial treatment for mental disorders, which targets at changing tactics of patients to cope with problems in cognition (such as belief and thought) and behaviour. Zhang et. al. (2018) carried out a systematic review and meta-analysis of literature aimed at evaluating the efficacy of using CBT and its modifications for reducing relapse of Major Depressive Disorder. This review found that CBT was effective for prevention of relapses in depression, both in the short term and in the long term.

Another systematic review and meta-analysis of literature was carried out by Huang et. al. (2018) with the purpose of exploring if CBT was a good choice for helping women with postnatal depression. Their conclusion was that CBT is sufficient to relieve the psychological symptoms of postnatal depression and effectively improve the quality of life in new mothers, resulting in a reduced prevalence of postnatal depression.

Since CBT is an eclectic mix of strategies, it can be easily adaptable to different contexts aimed at treating depression, including the Mkushi context. What is not known is whether this type of therapy was used at all among the women with depression in Mkushi.

2.2 Causes of Depression among Women

Depression is not just about mood fluctuations that people regularly experience as a part of life.

It is a mood disorder that involves a persistent feeling of sadness and loss of interest and ultimately causes dysfunction in one's life. Munakampe (2020) advances that ... most female patients in the hospitals in Zambia suffered from depression. The study is lacking though, in reporting what experiences these women with depression had with regards the rehabilitation or even what methods were used. There are several various causes of depression among women which fall into categories such as biological factors, environmental factors, social factors and lifestyle factors (Schimelpfening, 2020).

Biological factors include things like compromised levels of neurotransmitters, genetic/family history of depression passed down through the generations, hormonal imbalances and suffering from chronic pain. McKee and Kelly (2020) published an article addressing key concepts of the

assessment and management of commonly encountered types of psychological distress in serious illness. They advance that the varied physical, social and psychological stressors that accompany advanced disease can be burdensome and cause intense emotional suffering, hindering the ability of patients to cope in day to day life and affecting their ability to endure or adhere to recommended treatments. A study aimed at replicating, in Zambia, a recent global study by the World Health Organisation, which reported that the odds of depression were not increased in African people with diabetes was conducted. (Hapunda, et. al., 2015) found that depression is a common comorbid health problem among Zambian people with Diabetes. These two studies show that sometimes depression can be caused by advanced disease convalescence for example, living with diabetes for many years. It is not known if this being intensely sick for long periods also causes depression among women in Mkushi.

Environmental factors include things like early childhood trauma or abuse, gender based violence and any other forms of household dysfunction involving spouses, children and any other family members. A systematic review of findings of longitudinal studies done by Paulson (2020), conducted to synthesize empirical literature on the associations between Intimate Partner Violence (e.g., before pregnancy, during pregnancy, postpartum) and post-traumatic stress and depression symptoms in the perinatal period, corroborates this in their findings which state that intimate partner violence and depression have a very strong correlation.

In an experimental study conducted to test the effectiveness of clients-centred therapy (CCT) for the treatment of major depression in Malay women, it was found that the major causes of depression were issues with relationships with significant others, anxiety and distorted self-perception, childhood traumatic experiences and terminal illness (Khan and Khan, 2012). In a meta-ethnography synthesis of experiences and perceptions of 379 women across 13 studies in India, Bhattacharya et. al. (2018) identified the causes of depression among women to be interpersonal conflict, carrying the greater burden of caregiving, domestic violence, financial insecurity, adverse reproductive events, and widowhood. Perceived causes of depression were primarily relational and economic.

Findings of a study by Wong et. al. (2017), on depression, alcohol use, and stigma in younger versus older HIV-infected pregnant women initiating antiretroviral therapy in Cape Town, South Africa, found that young HIV-infected pregnant women in South Africa were more likely to

report depressive symptoms and self-harming thoughts compared to older women. The study also found that HIV-related stigma and intimate partner violence may be moderating factors. A study by Mapayi (2013) exploring the Impact of intimate partner violence on anxiety and depression amongst women in Ile-Ife, Nigeria, found that women were ten times more likely to report being depressed and 17 times more likely to report anxiety if they were in violent relationships. During the first quarter of 2019, the Zambia police recorded 5,584 cases of Gender Based Violence. In the first quarter of 2020, the police recorded 5,040 cases of Gender Based Violence (GBV) countrywide. The Central Province which is where Mkushi is found, 567 cases were reported translating to 11.3% of cases countrywide. Mapayi et. al.'s 2013 study findings make it important to find out if GBV also causes depression among women in Mkushi.

In a study conducted at 3 public antenatal clinics located in refugee-dense geographic areas in Sydney and Melbourne, Australia, women who identified as refugees were recruited from Arabic-speaking countries, Sudan, and Sri Lanka. They were recruited because they were at a heightened risk of Major Depressive Disorder for several reasons (Rees et. al. (2019)). Some of these reasons were, that the refugee experience exposes women first to the traumatic events of mass conflict and then to more general traumatic events like accidents, natural disasters, incidental forms of violence and abuse during the often prolonged period of transition as they pursue hazardous journeys and insecure places of temporary refuge on their route to countries of permanent resettlement (Rees et. al. (2019)).

The above studies have in common Intimate Partner Violence as a major cause of depression among women. What is not known is whether this phenomenon is also true about causing depression among women in Mkushi.

Social factors that cause depression could include things like personality types. Certain personality types are more predisposed to depression than others. Social factors could also include stress and conflict in the workplace or at home and grief from a significant loss. Sometimes stigma experienced because of one's condition also leads some to experience depression. In a study contextualizing understandings of depression among post-partum women in Malawi, it was found that HIV-associated stigma was commonly identified as a cause of depression (Harrington et. al., 2021). A study aimed at understanding how depression is debated, deployed and described in Sub-Saharan Africa, concluded that depression has roots in social

adversity, predominantly economic and relationship problems, sometimes entangled with HIV (Maystone et. al., 2020). A research primer on Major Depressive Disorder by Otte et. al. (2016), reveals that women are more than twice as likely to start drinking heavily if they have a history of depression, and are more likely to overdo it. What is not known is whether social ills as from the studies above (HIV-associated stigma, social adversity, drinking heavily), are also linked to depression among women in Mkushi.

The same study by Rees et. al. (2019) revealed that loss of family and social networks which add to refugees women's isolation and cultural alienation in the new country, especially during pregnancy, and material losses and difficulties finding work after settlement which result in more severe financial hardships for women who identify as refugees also cause depression (Rees et. al. (2019). The study also revealed a wide variety of causes ranging from natural disasters, to incidental form of violence, to intimate mate partner violence, loss of social support systems, to pregnancy and to material loss (Rees et. al. (2019). Mkushi does not have refugees per se but there are many Zambians who transfer there for seasonal jobs in the farm block or who have immigrated there to establish livelihood, (such as the white farmers who fled Zimbabwe after that country's new land reforms). What is not known is whether depression can be caused by similar issues (loss of social networks, material losses, natural disasters etc.) for women who migrate and immigrate to Mkushi.

Several individual studies and meta-analyses carried out by Hegarty et. al. (2019) aimed at evaluating the prevention of mother to child transmission of HIV in Kenya, link depression to adverse HIV-related outcomes among people living with HIV. A study by Adeponle (2017) on perspectives of women, family caregivers and health care providers in Nigeria, advanced that causal explanations for depression included husband's lack of care, family problems, "spiritual attacks", having a female child when a male child was desired, and not resting sufficiently after childbirth. These two studies show that living with HIV and the outcomes thereof, as well as social and cultural issues such as a husband's lack of care, family problems, "spiritual attacks", having a female child when a male child was desired, and not resting sufficiently after childbirth, all cause depression among women. Social and cultural profiles of Nigeria and Kenya are somewhat similar to that of Zambia. Assessing if these causes of depression are true for Mkushi as well would be helpful in the quest to get women with depression rehabilitated.

Lifestyle factors that cause depression include things like medication side effects, diets and substance abuse such as drugs and alcohol. Usually, people with major depression also have an alcohol problem and/or a drug use problem because they use these two substances to numb the effects of their depression. Alcohol itself is a depressant which just triggers a cycle that is hard to break out of for someone with depression who consumes excess amounts of alcohol. A systematic review and meta-analysis aimed to estimate the prevalence of Substance Use Disorders in subjects diagnosed with a major depressive disorder in community inpatient and outpatient settings was carried out by Hunt, et. al. (2020). They found that there was a correlation between Substance Use Disorders and Major Depressive Disorder. What is unknown is if there would be a similar correlation among women with depression in Mkushi.

Understanding the main causes of depression among women is important because it helps to design interventions that are woman-friendly and can fully help women to overcome their mental illness. It is not known what the causes of depression in Mkushi are though, hence the need for this study.

2.3 Experiences of women on Rehabilitation Counselling

Knowing and understanding the experiences of women with depression is ultimately helpful in that it informs what would be the best intervention methods to employ, how best to employ them, and what to expect. An experimental study was conducted to test the effectiveness of clients-centred therapy (CCT) for the treatment of depression in Malay women (Khan and Khan, 2012). CCT is a non-directive form of talk therapy designed to help clients grow psychologically, become more self-aware and change their behaviour via self-direction (Cherry, 2021). A review of the experiences of the Malay women with depression revealed that they were involved in client-centred therapy sessions that took about 45 to 60 minutes. The women's evaluations regarding their therapy sessions were that they were feeling good, less stressed, feeling more at peace with themselves, feeling relieved, having no more restlessness and sadness, and feeling less angry (Khan and Khan, 2012). Progress or improvement in behaviour reported by the women included improved appetite, improved relationship with husband, more confident to make decisions, more motivated to get better, and better appreciation of family members (Khan and Khan, 2012). Some of the specific decisions made by the participants were; arranging for a transfer, a new approach in communicating with husband, moving abroad for better income,

getting involved in charity work, and arranging for a holiday with children. Experiences of these Malay women reveal that there are tried and tested approaches to rehabilitation of women with depression such as the client-centred therapy that can be employed to get women with depression to overcome their illness. Finding out if there are any such approaches to rehabilitation of women with depression in Mkushi is one of the purposes of this study.

A meta-ethnographic synthesis of qualitative research focusing on the United States of America, USA, and the United Kingdom, UK, was conducted to examine young women's perceptions of their mental health and wellbeing during and after pregnancy to provide new understandings of their experiences. The USA and the UK focused on policy and research for the prevention of teen pregnancies, so it was imperative that the women's own experiences be highlighted (Lucas et. al., 2019). Women's experiences of depression as dark and inexpressible related not only to the sense that they could not describe their feelings, but also that they should not disclose their feelings, fearing judgement in relation to their ability to parent. This inability to express themselves also related to the way in which young women did not recognise those feelings as problems of mental health but of living through difficult life circumstances (Lucas et. al., 2019). The synthesis revealed that circles of family or social support around the young women could be powerful in helping young women's sense of wellbeing. Family and friends provided positive validation, which increased the young women's sense of feeling good and enabled them to develop new and positive adult relationships and could lead to them seeking professional help for mental health problems if needed (Lucas et. al., 2019). In a rural place like Mkushi, where the cultural values would interpret depression as a sign of weakness, circles of family and friends would go a long way in helping women with depression. This is a good angle to verify when looking into the experiences of women with depression in Mkushi.

A similar qualitative study by Haynes (2019), was carried out to understand the phenomenon of help-seeking for Black Superwomen who experience psychological distress in America. Findings indicated that women experiencing psychological distress sought help from external sources by utilizing informal supports and professional services, as well as utilizing internal coping strategies and avoidant coping strategies as a means of seeking help from within. According to Haynes (2019), findings from the study also reveal that it is necessary for counselling professionals to... consider integrating cultural-based theories that promote empowerment for

women of colour, which can prove effective in developing interventions that address the black woman's perceived relentless strength and excessive self-sacrifice which often results in increased distress. Considering that seeking help from external sources by utilizing informal supports and professional services, as well as utilizing internal coping strategies and avoidant coping strategies as a means of seeking help from within are values in Zambian culture, it would be prudent to find out if women in Mkushi also find support systems outside of the mental health profession by looking amongst their own social networks. It would also help to know if women in Mkushi also utilise internal coping strategies as well as avoidant coping strategies. Bhattacharya et. al. (2018) agree with the above two study findings; social supports such as a supportive spouse, families, friends, and most importantly children, helped women cope with daily stressors and reduced their vulnerability to depression.

Bhattacharya et. al. (2018) carried out a meta-ethnographic study on women's experiences and perceptions of depression in India. The study found that women struggling with depression expressed somatic complaints that included aches and pains (most commonly in the limbs, joints, head, and stomach), autonomic symptoms (i.e., palpitations, giddiness, fainting, difficulty breathing, and trembling), weakness and tiredness, behavioural symptoms (lack of sleep, appetite), and gynaecological symptoms, including abnormal vaginal discharge, genital itching, and menstrual pain. They also complained of hypertension, backaches, fever, arthritis, and indigestion (Bhattacharya et. al., 2018). They also described depressive symptoms that included dysphoria, tearfulness, poor appetite, weight loss, sleep difficulties, feelings of worthlessness, and loss of interest in usual activities. Others reported sadness, grief, recurrent nightmares, hopelessness, helplessness, sadness, anger, reduced desire to live, suicidal ideation, and suicide attempts (Bhattacharya et. al. (2018).

The findings by Bhattacharya et. al. (2018) show that there is a wide variety of ways women experienced depression ranging from physical symptoms to biological illnesses to emotional as well as social issues. These seem to form an exhaustive list that would be helpful in analysing if women in Mkushi also experienced similar.

Bhattacharya et. al. (2018) also revealed that several of these women sought the help of traditional home remedies and religious support. In that regard, Zambian culture also values traditional home remedies as well as religion. This angle of seeking help for depression is worth

pursuing to find out if women from Mkushi also sought help from home remedies and from the religious practices. A few women also reported feeling aided by antidepressant medications hence the need to explore if women in Mkushi were also treated through medications.

Despite the lack of information to do specifically with women's experiences with depression in Zambia, particularly Mkushi, the World Health Organization, WHO, puts the country estimate of the prevalence of depressive disorders in Zambia at 636, 819 people who account for about 4 percent of the country's population (WHO, 2017), which stands at almost 17.9 million people (World Bank, 2021). The general assumption for a person afflicted with a depressive disorder or depression is that they will be screened or assessed, diagnosed and treated, just like they would be if they had Malaria for example. Therefore, one would assume that there would be a system within which someone with depression could operate to get help through a general method such as rehabilitation counselling. One would even assume that there would be medical records or at the very least, statistics showing the prevalence and treatment of such an illness over time. What is not known is whether women in Mkushi who have depression, would have a system to operate in which involves screening, diagnosis and treatment through rehabilitation counselling.

Phiri (2018), in her report on mental health advocacy in Zambia, advances that the Ministry of Health does recognise mental health as one of the country's top public-health challenges, but also adds that there have been no extensive studies to determine the extent of mental illness in Zambia.

So going by the literature above, there are people struggling with depression in Zambia, except there is little information to account for where they are at and what kind of help they might be receiving. The WHO (2020) again advances that although there are known, effective treatments for mental disorders, between 76% and 85% of people in low- and middle-income countries receive no treatment for their disorder (WHO, 2020) making it hard to hear about people's experience on how they were helped.

Another possible reason there is little information or literature on experiences of women receiving treatment for their depression is deeply embedded in the culture of the people. In a study aimed at exploring the barriers to the use of mental health services in Zambia, Munakampe (2020) advanced that a lack of understanding of the illness sends people to seeking traditional healers, losing out on the opportunity to have their experiences documented for reference. Some

may also attribute their mental illnesses to demonic oppression and/or spiritual attacks and seek treatment from the spirituality through exorcism and breaking down of perceived curses as a result of sin (Nasrallah, 2016, Irmak, 2014, Pietkiewicz, 2021). Again this causes them to lose opportunities for diagnosis and treatment. A mental illness or disorder, whether it be depression, bipolar disorder, substance abuse, or anxiety (Munakampe, 2020), is a health problem just the same way a physical illness is. For example, an individual cannot control a depression any more than he or she can control diabetes or Malaria. The illness must be diagnosed and treated.

In qualitative study done in Brazil by Zimmermann, Nunes and Fleck (2018), to investigate the effect of depressive status on responses to items on the WHO quality of life assessment instrument, adult women with depression seeking outpatient care were assessed at the beginning of the study, and 6 months later after they received care. Areas like quality of life, physical and emotional pain, sleeping well, ability to function at work, dependence on medication etc., were investigated. The authors reported improvement in the depressive symptoms that had previously interfered with the women's lives.

Experiences of diagnosis and treatment of women with depression go a long way in helping women to understand their mental illness, in building a model that would work for counselling women in light of their competing options of tackling their depression either through religion/spirituality or through African tradition and witch doctors. Experiences of women also go a long way in encouraging women to seek the help they need from credible and relevant mental health institutions and to fight the stigma that inevitably comes with having a mental illness.

Experiences such as the ones outlined in the studies above show that depression can be overcome and women can live depression free and become functional again if they receive timely and relevant help for their depression.

2.4 Hindrances to Rehabilitation Counselling for Women

Access to comprehensive, good quality primary health care is important but in the case of depression and other mental illnesses, there are considerable patient access barriers or hindrances keeping people from seeking the needed help. These range from personal issues such as people's low incomes and their related poverty, stigma born out of fear, shame, or lack of understanding

of the illness, to more impersonal policy issues such as low funding of the sector, legislation, etc., and facility issues such as difficulty in screening, diagnosis, management and/treatment because of human resource issues, lack of mental illness medicines/antipsychotics etc.

PERSONAL ISSUES

Poverty, defined as the lack of access to employment, income, freedom on which goods and services to consume, and a lack of other basic needs (Munakampe, 2020), increases one's predisposition to mental illness. Munakampe (2020) reports that about 60 percent of Zambians are classified as poor. The World Bank (2021) reports that Zambia ranks among the countries with highest levels of poverty ... globally. More than 58 percent of Zambia's 16.6 million people earn less than the international poverty line of \$1.90 per day ... and 3 quarters of the poor live in rural areas (World Bank, 2021). A significant portion of individuals with severe and persistent mental health conditions live in rural areas (Munakampe, 2020) where most of the poor live. A poll in which The Gallup-Healthways Well-Being Index conducted with a random phone-interview sample of United States of America adults and looked at the prevalence of chronic illnesses revealed that people living in poverty were twice as likely to have depression compared to those living at or above the poverty level (Abrams, 2012). Not only does living in poverty place a person at higher risk for depression but if they are unable to work, or do not have access to support and social services, mental illness can make it harder for someone to break out of a cycle of socioeconomic disadvantage. Finding out if poverty can be linked to depression for women in Mkushi also, would help in formulation of interventions that are helpful and relevant for the women.

Stigma is another issue that hinders people from accessing counselling for their depression. Stigma is shame or disgrace or humiliation people with mental illnesses and their relations suffer. It is born out of fear, shame, or lack of understanding of mental illness. Findings of a study by Mwape et. al. (2010), aimed at exploring health providers' views about mental health integration into primary health care in Zambia show that mental illness stigma and discrimination are prevalent across Zambian society, apparent within the general community, amongst family members, amid general and mental health care providers, and at the level of government. Stigma is fuelled by a lack of understanding of causes of mental illness; fears of contagion and the perceived dangerousness of people with mental illness (IBID).

Ngungu and Beezhold (2009) in their report on the challenges and way forward for mental health in Zambia, share the same sentiment in their assertion that high levels of stigma exist not only against those who are mentally ill but also against their families and those working in the mental health services. They also assert that because of stigma, many patients are disowned by their families. Some are even abandoned altogether (Phiri, 2018). Most long-stay patients in Chainama Hospital (the major mental health facility in Zambia) have no contact with their family members. The ‘out of sight out of mind’ mentality is prevalent (Ngungu and Beezhold, 2009). Rather than get health care for their mental illnesses, people would rather fit in or conform to the communities around them for fear of being socially excluded. It is not known if stigma also plays a role in keeping women with depression in Mkushi from seeking treatment.

Further compounding this issue is the fact that “mental health” is a widely misunderstood and often mysterious concept. There are so many mental health fallacies that work as a hindrance to accessing mental health services. Some originate mostly from fear, shame, or lack of understanding of the illness while others originate from cultural beliefs. Quoting Amuyunzu-Nyamango (2013), Mwambwa-Johnson (2021) reports from her study investigating the relationship between levels of Mental Health Literacy and attitudes and beliefs about mental illness and health-seeking behaviours of young adults in Zambia, that research shows that most African people still consider mental illness or mental disorders taboo diseases due to a pervasive culture of denial, myths, and negative perceptions that marginalize and ostracize people perceived to have mental illnesses. The Guardian, a South African news and media outlet, reported similarly how that more than 17 million people in South Africa for example, are believed to be dealing with mental health issues, and that although more than one in three South Africans are believed to be living with some form of mental illness, 75 percent are likely to never get treatment due to a number of reasons, one of which is widespread taboo surrounding the issue (The Guardian, 2021).

This is because to the average African, mental illnesses are hard to comprehend and are often interpreted as spiritual problems brought on by curses as a result of sin, or as problems brought about by witchcraft. Belief in spiritual curses as well as belief in witchcraft are a means to understand, interpret and accept mental illness as reality for most Africans. This study will find

out if these misconceptions about mental illness have led to missed opportunities for diagnosis, management or even treatment of depression among women in Mkushi also.

FACILITIES ISSUES

Ideally, women and everybody else are supposed to access care for their depression or other mental illnesses at the primary level in their local clinic. But primary health facilities and their inner workings can cause or be a hindrance to accessing counselling for depression. In some cases, it could be assumed that the women actually have sought care but their health facilities just do not have the capacity in terms of human resource, to help them. There seems to me a shortage of mental health care workers to meet the burden of demand (Munakampe, 2020), attributed to varied reasons. One reason is that most of the health workers who decided to take the mental health career path ended up disinterested because they did not have many opportunities to develop their careers unlike, for instance, their counterparts who pursue careers to do with HIV/AIDS issues (IBID). Another is that the mental health workers deployed to primary health facilities lack opportunities to practice and eventually get absorbed into mainstream healthcare (IBID).

This human resource problem leads to patients or clients either falling away without care, or being referred to secondary health facilities. As Munakampe (2020) put it, some of the cases seen at the secondary institutions could have been handled at the clinics and health posts, but because of lack of interest or experience in providing such services, they are referred to secondary health care facilities. With high costs of travel and upkeep, referred patients are likely to stop their pursuit of mental health care.

At the primary care level, the lack of essential medicines can also be a hindrance. Even when a health care provider was willing and able to provide services, the primary health care package had no medication to respond to the need for these services (IBID). The primary care kits with essential medicines needed to provide services were regularly provided to the health facilities. However, these kits did not contain drugs specific to mental health care. The lack of drugs was seen as a contributing factor to the many referrals at the provincial facilities from lower-level institutions. Where medicines are available, they are in short supply. It is not uncommon at primary care level for a prescription to be issued and the patient asked to fill it out at private

chemists or pharmacies outside the hospital. Here, the drugs were very costly, and this affected access to drugs when the patients needed them (IBID). It is not known if high costs of travel (for referrals) and high costs of medicines have impeded the seeking of treatment for women with depression in Mkushi.

POLICY ISSUES

The need for greater commitment from governments and policy-makers to mental health issues has never been greater than it is currently. Munakampe (2020) advances that historically, mental health care has been a neglected facet of the health system in Zambia, with services concentrated at provincial government hospitals and not at the primary care level. This neglect manifests in several ways with major ones being inadequate funding and lack of legislation.

Challenges due to inadequate funding pose a threat to provision of mental health care. Less than 1 percent of the national health budget is allocated to mental health (Munakampe, 2020) in Zambia. Insufficient funding comes loaded with issues such as: fewer opportunities for people to pursue mental health care training, fewer opportunities for health care providers to further their careers in mental health, the inadequate provision of medicines and inability to uplift the dilapidated physical states of the facilities. Ultimately, all these negatively affect the ability for women to access mental health care, specifically, counselling for their depression.

Apart from low funding, legislation is a major hindrance to women accessing care for depression as well as other mental illnesses. Even though mental illness is recognized as a serious challenge, laws governing mental health care are very old and outdated. The Zambian Mental Health Act of 2018 is in place, but has not been operationalized yet. This means there is no proper governance of safety and delivery of quality health care to people with mental illnesses both in the hospital and at home. One consequence of this is that family members are not compelled to seek mental health care for their patient or will abandoned their patient at mental hospitals without legal consequences. This leading to overcrowding and compromised care for the patients (Phiri, 2018). Also, patients are not legally protected from the community and be victims of violence because of their mental illness.

Barriers to rehabilitation counselling for women with depression exist. According to a study referred to earlier, by Bhattacharya et. al. (2018), for some women, limited financial resources

were a barrier to seeking help and treatment. A study by Watson et. al. (2019) that systematically reviewed experiences of ethnic minority women regarding perinatal mental health conditions and services in Europe, found a number of issues working as barriers toward women accessing these service. A lack of awareness about mental ill health, cultural expectations, ongoing stigma, culturally insensitive and fragmented health services and interactions with culturally incompetent and dismissive health providers all impact on ethnic minority women's ability to receive adequate perinatal mental health support in the UK (Watson et. al., 2019). A review of literature from qualitative studies around the world aimed at describing women's experiences of postpartum depression shows that nurses should judge the psychological status of pregnant women from the emotional and behavioural aspects, screen high-risk pregnant women with the Edinburgh Depression Scale, and intervene with depressed pregnant women, such as providing psychological support and knowledge education (Yahan and Yilan, 2019). A cross sectional survey of HIV positive pregnant women attending the Chitungwiza City Council antenatal clinics outside of Harare, Zimbabwe, was carried out by Nyamukoho, et. al. (2019). The survey revealed that using non-professionals who are trained to screen and identify those with probable depression during pregnancy and provide evidence based care management could considerably reduce the treatment gap for depression in pregnancy.

It would be prudent to find out if these barriers, (limited financial resources, a lack of awareness about mental ill health, cultural expectations, ongoing stigma, culturally insensitive and fragmented health services and interactions with culturally incompetent and dismissive health providers, a lack of screening of pregnant women with emotional and behavioural issues and even a lack of specially trained personnel to do the screening) also pose as barriers to women accessing treatment for depression in Mkushi.

2.5 Measures to Make Access to Rehabilitation Counselling Services Easy for Women

Since literature available suggests there are hindrances to accessing mental health care, it is imperative to also bear these in mind so that one knows how to mitigate them.

Depression is present in various demographics of women and can trigger other illnesses or problems. Catching it early hinges on whether active screening is present especially at basic or primary health care. A study by Ngocho et. al. (2019) was carried out to analyse depression and anxiety among pregnant women living with HIV in Kilimanjaro region, Tanzania. Results

revealed that depression and anxiety symptom were common in the sampled pregnant women living with HIV. A sizable number from the sample screened positive for comorbid depression and anxiety. The screening for depression was important in that the success of prevention of mother to child transmission (PMTCT) of HIV depended on how well the depression of the mother was handled (Ngocho et. al., 2019). It is hard for a woman with depression to fully comprehend and participate in such a programme as PMTCT. Prevalence rates of HIV in Zambia are high (UNICEF, 2021). There is therefore need to mirror such a study for purposes of successfully engaging women here in Zambia also, particularly Mkushi, in PMTCT care and support in case they are also dealing with depression. This would ensure protection of their children from also acquiring HIV.

A study was carried out by Bellhouse et. al. (2019) aimed at exploring the psychological distress experienced by women as a result of miscarriage, as well as the perceived support provided by healthcare professionals. This study gave out a number of recommendations provided by women to improve the service of healthcare providers in the event of a miscarriage. The women's recommendations included referral to a psychologist, and ongoing follow-up after their miscarriage, which women felt would assist them with managing their distress. The referral practice is supposed to be standard procedure in health care to make sure patients get holistic treatment. What is not known is whether women in Mkushi have experienced this service as it would shed light on their experiences with depression.

Fear, shame, or lack of understanding of the mental illness breeds negative attitudes towards mental illness and lead to lots of stigma against people with mental illnesses. Mwape et. al.'s 2010 study concluded that in Zambia, as in many other low-income African countries, very little attention is devoted to addressing the negative beliefs and behaviours surrounding mental illness, despite the devastating costs that ensue. Addressing this would entail basic mental health awareness and education that is culturally relevant for the community. This could be in the form of community based awareness campaigns specifically targeted at demystifying mental illnesses and explaining why and how they occur.

There is a high need to operationalize the new Mental Health Act of 2018. Munakampe (2020) advances that referencing the old Mental Disorders Act and implementation of the mental health policy was problematic because the two were not aligned on how to manage the patients. While

the policy stipulated mental health management and care, the law reinforced the use of violence to manage the patients, usually with the help of the police. Bridging the gap between these two hinges on the education of the mental health workers on what the new law entails. This will require regular consistent effort in the sensitization and education of the mental health workers about all the law stands for as well as its limitations when it comes to the daily treatment of people with mental health illnesses.

Human resource development at community level would go a long way in improving access to counselling for women. This could be modelled after similar endeavours that have been success stories such as the HIV/AIDS trained community counsellors. This is supported by a sentiment a respondent in the study by Munakampe (2020) gave about the training of mental health assistants, *if the same people in the community were able to be trained and then share the knowledge with the rest of the community, I think that would be very useful.*

Of course the more glaring measures that could make accessing counselling for depression as well as other mental health services easier for women involve improving overall funding of the mental health sector. This translates directly to improved services in that sufficient numbers of mental health workers could be trained, relevant drugs could be purchased, development of infrastructure embarked on etc.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Overview

This chapter presents the research design that was used in the study. It also presents the study area, study sample, sampling techniques used, data collection instruments used, procedures used for data collection, the time line and the data analysis instruments and procedures used.

3.1 Research Design

The interpretive phenomenological design was employed in this study because it helped in the understanding of the lived or subjective experiences of women who had depression. The study looked at the reality of respondents' narratives of their experiences to produce in-depth descriptions of the phenomenon under study: experiences of how rehabilitation counselling helped them with their depression.

3.2 Study Population

This study's population included women in Mkushi, who had depression before and received treatment. These women were between the ages of 18 to 45.

3.3 Study Sample

Eight women who had depression were selected to be part of the study. Being a qualitative study, the goal with this small sample size was the attainment of data saturation where adding more participants would not add any more valuable data to the research.

3.4 Sampling Techniques

This study used Criterion Sampling which is similar to purposive sampling (the intentional selection of informants based on their ability to elucidate a specific theme, concept, or phenomenon). The criterion of importance here was depression. Criterion Sampling was used because this method brought together participants with a shared experience, that of having suffered from depression and receiving rehabilitation. Even though their individual experiences varied, their shared qualification for being part of the study was that they all suffered from depression and received treatment. A list of these patients was obtained from patient records at the Mkushi General Hospital. Those who had had multiple contact times with mental health staff were then selected. They were contacted and those willing to be part of this study were included on the list of eight women to be interviewed.

3.5 Data Collection Instruments

An Interview Guide was used to collect data from participants during in-depth interviews of women with depression. The interview guide was a list of questions and/or topics the researcher covered during the course of the interviews.

3.6 Data Collection Procedure and Time Line

Unstructured, in-depth phenomenological interviews were carried out in this study. This was done face to face so that rapport could be created with respondents. Even if these were unstructured interviews, this researcher used an interview guide to draw out the respondent's experiences through open ended questioning just to cover all the bases. The researcher also noted and read the body language of the participants to add a higher level of understanding to the responses.

Each participant was assured of their anonymity and as such was assigned a code as their identification. This study used letters of the alphabet and their corresponding position in the alphabet to show the sequence the interviews occurred in, for example, "Participant A1", which meant "*Participant A was first interviewee, or Participant B2 was the second interviewee*" etc.

With the permission of each participant, audio recording of the interviews was done using an Android mobile phone application called Recorder version 3(54.1). Thereafter, transcription of the interview, word for word, was done to avoid any loss of data. All data was stored on a computer as well as a back-up drive. Note taking where necessary was employed for added remembrance of the data collected.

The data from the interviews was collected over an estimated period of 1 month starting June 1st to July 1st, 2021.

3.7 Data Analysis

Data analysis for this phenomenological study was ongoing starting from the very inception of data collection. The goal of the analysis was to achieve an understanding of patterns of meanings from data on lived subjective experiences of participants who had depression as they described their experiences during the interviews.

Thematic analysis of qualitative data was employed. Firstly, this researcher transcribed the data audio recorded word for word. Secondly, the researcher immersed herself in the data to achieve

familiarity by listening to the recordings and reading the transcribed data extensively. Thirdly, through the listening and reading, the researcher explored the experiences expressed in the data by the participants with the view to find and highlight original information rather than what is already out there as common knowledge. Fourthly, the original information found and highlighted was then further studied to look for meaningful units, themes and/or patterns while continually relating these to the objectives of the study. Divergent views, if any, were noted and explanations sought with further probing of various ways in which the participants experienced the phenomenon. Lastly, the researcher organised and constructed a composite of all the themes and patterns into an informative package that answered the questions of the research or study as experienced by the participants of the study.

3.8 Ethical Considerations

Given the sensitivity of the research, it was necessary to get the informed consent of possible participants of the study. It was also imperative that the participants voluntarily take part in the study and not be coerced to because the success of this study was owed to them. Also imperative was to assure the participants of their anonymity and confidentiality in the information they provide. Respondents were not asked to identify themselves by name during the use of the research instruments. Also care was taken to get the respondents' co-operation during the research. If at any point they felt they needed to leave, they were given the freedom to.

CHAPTER FOUR: FINDINGS OF THE STUDY

4.0 Overview

This chapter presents the findings of this phenomenological study based on the research questions of the study. The following were the research questions: What are the main causes of depression among women in Mkushi District; What are the experiences of women in Mkushi, in terms of how Rehabilitation Counselling helped them with their depression; What are the major hindrances if any, to accessing depression rehabilitation counselling among women in Mkushi District; and What measures could make accessing Rehabilitation Counselling services easier for women in Mkushi District? The findings are presented under thematic areas identified, guided by the study questions.

The study consisted of 8 respondents who ranged in age from 18 to 38 years old, specifically, an 18-year-old, a 20-year-old, a 28-year-old, 31-year-old, a 33-year-old, a 34-year-old, a 36-year-old and a 38-year-old. This could be because depression is not really specific to any age group. Children, teens, young adults, midlife adults and senior adults alike are all vulnerable to depression. Levine (2017) advances that depression knows no age, but teens, seniors and anyone going through a major life change are more at risk.

The women in this study were also varied in educational attainment from grade 7 up to a bachelor's degree, specifically, a grade 7, two grade 9s, two grade 12s, two diplomas, and one bachelor's. This shows that the prevalence of depression is not limited to a specific demographic of educational level. Anyone can get depression regardless of their educational attainment. As Morin (2021) put it, Depression ... can affect people ... across all socioeconomic statuses.

4.1 Causes of Depression among Women

Asked what they thought the causes of depression among women in Mkushi were, Results indicated that the respondents mentioned a variety of causes ranging from illnesses like HIV to personal to relational to socio-economic, to security.

Just thinking, but probably marital problems, unemployment issues, gender based violence. I'm sure there are a lot. Diseases like HIV, even cancer.

Respondent B2

I think cheating husbands definitely contribute. And being beaten by your husband a lot. I think even being a widow because you have lost the one who takes care of the family. HIV has created many women who I think are depressed.

Respondent C3

Not really sure, I have never thought about it. Maybe gender based violence, HIV and husbands cheating.

Respondent D4

No clue. Maybe lack of income, no plans for the future, no money for school. I don't know.

Respondent E5

What are the causes of depression? I think things like social and relational problems, marital problems, infertility, not achieving what you want. Those are the ones I can think of.

Respondent F6

A follow up question asked the respondents what may have caused their own depression. The respondents gave a wide range of responses showing that there is not any one major cause of depression but a variety of them. One of the notable ones was that most of the women reported spousal/husband-related problems. This shows that the role of the husband in the home is key. The husband's negative actions create issues of financial insecurity either for the present or for the future in the home, and can easily trigger the development of depression in a wife. This is what the respondents had to say:

My husband left me and all our 3 children to live with his girlfriend. He calls me names, saying I'm ugly and don't bath. He threatens to kick us out of the house we built together, sometimes he doesn't buy food and the children go to bed hungry. I have no education or enough money to provide for the children. I don't know how we will survive.

Respondent A1

My husband became verbally abusive calling me unproductive and good for nothing. Then he started seeing other women. I don't have a personal income or just money of my own so I can't say anything. Not even when his young brothers that we keep insult me. He even says some of these things in front of his young brothers.

Respondent C3

My husband is our breadwinner and provides well for us. The only problem is that he is losing his mind, going mad. How will we live? I didn't go far with school and have no job.

Respondent G7

There are other equally important triggers of depression though such as infertility, chronic illness and failure/not achieving academic targets, verbal and emotional abuse. The respondents said the following:

Mainly just not achieving what I really want. I really want a baby; it's been 3 years since I got married but have not borne my husband a child. This makes me sad and afraid I will never have one or maybe I will lose my husband. And people talk a lot behind my back. It is really hard.

Respondent F6

I think not knowing when I will get well, I have been sick for a while. And other issues also. I fell behind in my school work. My friends are starting college and I haven't finished grade 12 yet. I don't even know when I will finish because I'm still sick.

Respondent E5

Just being unable to get well and tend to my family for so long, especially when I have no idea what is causing my anxiety and chronic fatigue. My girls are growing up with a sick mum and I can even explain properly what I am sick of or why it's taking so long to get better.

Respondent B2

4.2 Experiences of Women on Rehabilitation Counselling

Asked what the experiences of how Rehabilitation Counselling helped women with depression in Mkushi, results showed that over half the respondents did not know about any rehabilitation counselling experiences of other women. The responses show that this could be because women are afraid of being stigmatised or women just do not know of the existence of this service.

Some of the women who said they had no idea had this to say:

No, I have never heard of any woman's experience with this. These types of illnesses are secrets that are not supposed to be aired anyhow. So women do not share them because they are afraid of what others will say.

Respondent A1

I really don't know. People don't really talk about such stuff, but I'm sure it's there.

Respondent C3

I do not know anyone who has received rehabilitation counselling before. I don't think women know that you can go to the hospital for such a thing. Even I didn't know until recently.

Respondent H8

These three responses were reminiscent of the reasons the other respondents gave for not knowing any experiences of other women who had received rehabilitation counselling before. The situation was different for respondents who knew of experiences of women with depression.

Responses show that there are other places where people can access rehabilitation counselling services such as the clergy or even the village council. These are the narratives of 2 respondents who knew of experiences of women who had received rehabilitation counselling in places other than the hospital;

The lady I know who has been counselled before is my sister who used to talk with her pastor at church. That lady pastor had also gone through some hard stuff so what she said was really good and helped change my sister's life. She was really in a bad place.

Respondent B2

Where I live, we have no such people as counsellors. So when one has problems, they talk either to the 'bashi-bukombe or bana-bukombe' (male or female marriage go-betweens). If it is about issues other than marriage problems, then we go to the palace to talk with the advisers or court officials there.

Respondent G7

The respondents were then asked what their personal experiences of how Rehabilitation Counselling helped them with their depression. It was found that again, over half of the women had nothing to share as they stated they had never personally received any counselling. This shows that rehabilitation counselling is a service that is not pursued by many women for various reasons. Some just do not know the service exists, and some had no idea they could be treated using that approach. Some of the respondents who 'had never been counselled' mentioned:

I haven't really had any formal counselling; I didn't know I needed it. The closest is when maybe, talking to friends or my sister. They are not really counsellors but it helps.

Respondent F6

I have never been counselled because it never really crossed my mind to do that.

Respondent A1

The 2 respondents who had been counselled shared having benefitted greatly from their experiences of rehabilitation counselling for their depression. It gave credence to their illness, they felt heard and understood and worked on solutions for some of their problems. This shows

that despite the few who do get counselled benefit in ways that help them heal from their depression. They stated:

The highlight for me is that it legitimised how I was feeling, it made me feel relieved that someone understood how I was feeling and had an idea how to help me. I just needed to talk to someone who would understand.

Respondent B2

It has been good to have someone listen to me and help me to think about solutions to my problems.

Respondent C3

These 2 responses are indicative of just how beneficial and important counselling is to those who seek and receive it despite it seemingly not being a sought after service.

As a follow up, the respondents were asked to describe how they were treated for their depression, where and by whom. It was found that the respondents who stated never having been counselled before also stated they had never been treated for depression, stating possible reasons why; afraid being embarrassed, did not know they needed treatment, did not know hospitals had the service to help them. The following are some of their narratives:

I have not experienced any treatment by anyone anywhere. I was going to ask how that works. You know, if I need it. Maybe. I just don't want to be embarrassed.

Respondent D4

I have never been treated. Like I said, I didn't know I needed it. I just wanted the situation to end.

Respondent F6

I have never done it, never been treated. I just didn't think that hospitals treat these kinds of things. We will see.

Respondent A1

For the 2 who had received counselling, 1 said,

The doctor at the hospital diagnosed me with depression, anxiety and chronic fatigue. He prescribed an antidepressant to take, then he referred me to see a specialist who turned out to be a psychiatrist in Lusaka. But the best was when I got to spend time with a counsellor who helped me to try some things I could do personally on my own at home to get better.

Respondent B2

The second respondent stated,

Just counselling. I talked to a counsellor at the hospital, I think she was just one of the nurses though. It was just once but I went home feeling better.

Respondent C3

These responses reveal some essential services that all fall under rehabilitation counselling; diagnosis; the taking of depression medication, referral to a specialist better able to help and counselling itself. These are services that the 6 women who had never been counselled were also missing out on.

A follow-up question was tabled asking the respondents to say whether their experience of their treatment was sufficient. It was found that the two who had been treated would have preferred to experience a little more of what rehabilitation counselling has to offer as they could. More than just one counselling session, as well as couples' therapy, are two ways that rehabilitation counselling is helpful to women with depression as shows in the responses:

So far it is helpful. Given the chance, I would like to continue with the counselling so that I can have someone to talk to until I'm able to stand on my own two feet.

Respondent B2

I think it was helpful for me. It would have better if also my husband can receive it, I mean the counselling. I just don't want to keep arguing and fighting with him all the time. I'm tired.

Respondent C3

Another follow up question was tabled asking the respondents what kind of treatment or help they felt benefitted them (currently), or would have benefitted (in the future) them the most. Seven out of 8 respondents all mentioned *counselling* or *talking to someone*, as a desired mode of treatment showing that given a chance, people out there were in major need of help, and were willing to seek out the services of a counsellor. The reasons for needing counselling were also varied as expressed by the respondents, also indicating just how varied their cases were. Their responses were:

Someone to talk to and help me start a business, I want to be able to buy food for my children and take them to school. Doctor, I also need someone to help my marriage and talk to my husband. Maybe at the hospital he can listen.

Respondent A1

Counselling definitely. I have just had a hard time and I feel like people are tired of me not being well. I don't want to be a burden; I want to take care of my girls. I think the antidepressants and anti-anxiety are also very helpful because I can do some of my normal functions as long as I take them every day. But I don't want to take them forever.

Respondent B2

I want to be helped. But people talk. What will help me is talking to a counsellor who will not broadcast my problems to everyone in the community.

Respondent G7

Results also showed that some respondents wanted more than just counselling, that they would have had fuller and more helpful experiences if they had had access to the other services that are encompassed in rehabilitation counselling such as diagnosis, couples/marriage counselling, knowledge about the illness (causes, symptoms, treatment), medication and ongoing counselling.

Maybe I could have done some tests. Knowing I have this illness would have helped me to see a counsellor sooner. I didn't even know I could have it or even how it comes.

Respondent C3

Maybe someone to help me understand, to explain the disease so that I know. Even medicine if it can heal me.

Respondent D4

Seeing a counsellor. Maybe some couples counselling because my problem involves my husband.

Respondent F6

4.3 Hindrances to Rehabilitation Counselling for Women

Asked what they thought are hindrances, if any, to accessing depression rehabilitation counselling among women in Mkushi District, the respondents gave varied answers. Their responses show that the general consensus is that the women have very little to no information at all about how to get rehabilitation counselling. Rather than be vulnerable at a hospital, they would rather stay home where they feel safe. Some women had this to say:

Not knowing where to go to get help. Is it OPD (out patients department)? Or VSU (Victim Support Unit)? Or to church? Or bashi-bukombe (male marriage go-between)? What do I say when I get there? I don't know. It's hard to just go to the hospital to say my husband is cheating on me. Or that I have no money to feed my kids. How can that be an illness? There is no medicine for that.

Respondent C3

I think women just don't know that such things exist. But also, we just don't even know we have depression or how we can be treated. For me that is where I would just stay home and leave it at that. Am I even really sick after all? Besides, what will people think?

Respondent B2

Probably knowing where to find a counsellor, like they do for ART. For them it's clear, the room is labelled, the counsellors are known, they are the same ones each time you go, they even become your friends. Even knowing what day the counsellor is available. I don't know anything.

Respondent F6

Not being sure where to go is a problem, you can just be embarrassed with so many people at the hospital. You don't even know who to ask or even what to say. And then is it available at every clinic or do I always have to come to Mkushi? Also being afraid to ask because the nurses shout at us.

Respondent G7

4.4 Measures to Make Access to Rehabilitation Counselling Services Easy for Women

Asked what measures could make accessing Rehabilitation Counselling services easier for women in Mkushi District, the women gave varied responses. Results show that the major hindrance was a lack of basic knowledge about not just the illness itself, but also about how to go about getting help and where to go exactly to get the help. The respondents had this to say:

Maybe if everyone knew this service is available, if there are posters the way there are for HIV and cervical cancer. The cervical cancer people even have weekly meetings and they get reminded when they go for ART and antenatal. Maybe we can have also for mental health.

Respondent B2

I wouldn't even know where to start. I have no idea. Maybe if there was a way to go to the hospital specifically to see a counsellor it can make thing easier. I just don't want to go through nurses there where you take you card before seeing the doctor. There are too many people in there, no privacy. And Mkushi is small, we know each other.

Respondent C3

I don't like hospitals. I just never know where to go. What would help me is to know exactly where to go and to have easy access to a counsellor. So I need to know where to go and the also what to do and what to say. Will the counsellor understand me and help me, because sometimes I don't understand myself. I don't really know what my illness is all about.

Respondent E5

Maybe having some women to talk to who are known counsellors. I wouldn't want to talk to a man about my issues.

Respondent G7

A follow up question was tabled, about what they thought could make or would have made getting treatment easier for them personally. The results showed similar sentiments as from the previous question, that knowledge pertaining to the illness itself, the process/or steps taken to get treatment would be helpful and who to see. The respondents said:

Knowing where to go, who to see, a clear process. Maybe even making appointments. Having a specific day and counsellor to see who knows my case and history well, who I can trust.

Respondent B2

If I knew that the hospital had someone who is employed just to deal with emotional issues. Or even the police maybe. Anyway just the same thing I said earlier.

Respondent C3

Someone to explain to me what was going on. Maybe knowing that I can have this illness even when I'm still young, and knowing where to go to get help.

Respondent D4

Knowing I could have easily just gone to the hospital and see a counsellor. Even knowing I have the illness.

Respondent E5

This follow-up question was similar to the previous one, asking what the respondents thought could make or could have made getting treatment harder for them personally. The results showed that some respondents still said the lack of information makes/could make getting treatment harder:

The same thing I guess. I just want to know how to see the counsellor? Some days are just bad and you are not really sick physically but you just want to talk to someone. I mean if there is someone professional to help, then why not. So when to see a counsellor, is it any time or what?

Respondent C3

I like to read things, like google. So I would have been reading on my own because knowing nothing about the disease is not good. But sometimes it's good to have someone explain exactly what is going on.

Respondent D4

I guess like before, not knowing who to see. It's like going in blindly, it's not a pleasant experience.

Respondent E5

Not knowing where to go and who to talk to. I have had bad experiences with nurses, so I prefer to be prepared.

Respondent H8 drunk

It also found that other issues such as the lack of confidentiality, long waiting periods, a lack of services in their local clinic, changing counsellors, were reported as making or would make getting treatment harder for the respondents:

I don't like how open it is there with the nurses and patients listening and everybody knowing my problems and asking questions.

Respondent A1

I would prefer to have the same counsellor, someone I can be comfortable with and I just want to talk to that person each time. Changing counsellors would be hard. Also the long queues take too much time. And if I don't know where to go, I would rather just stay home.

Respondent B2

The distance is a big factor for me. Having to come all the way to Mkushi to see a counsellor, it is too far and transport is expensive. And it just takes too much time. And I don't even know if I will receive help. Because sometimes you go to the hospital and are told the doctor is in the theatre or in the ward. Or you just find a long queue.

Respondent G7

4.5 Summary of the Chapter

In summary, as regards to causes of depression among women in Mkushi, it was found that the following were the causes were: infidelity of the husband, unemployment, gender based violence, diseases like HIV and cancer, a lack of income, lack of plans for the future, a lack of school fees, infertility, lack of achievement, verbal and emotional abuse. In terms of how the women were helped through RC, it was found that they were helped by having someone to talk to who would not judge them, which legitimised how they were feeling, helped them feel relieved that someone understood who had an idea how they could be helped, someone who could listen and help them think about solutions to their problems. In terms of hindrances, it was found that the women were not even aware that they had the condition or illness, or have knowledge about their illness such as the causes, symptoms and treatment and where to go to access treatment, when to access treatment. It was therefore suggested that the following measures would make rehabilitation counselling easier to access: information like posters about what depression is, its symptoms and how it is treatment, information about the steps to take to

seek rehabilitation counselling, information about what days rehabilitation counselling services are available, information about where to go and who to see (which counsellor) for rehabilitation counselling.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.0 Overview

The purpose of this study was to explore the experiences of women who had depression in Mkushi district, in terms of how rehabilitation counselling helped them. This chapter is a discussion of the findings arising from interviews conducted for this study. Thematic analysis of the qualitative data derived was done under each of the research objectives of the study which were to establish the causes of depression among young women in Mkushi District, to explore experiences of how rehabilitation counselling helped women with depression in Mkushi District, to identify major hindrances if any, to accessing depression rehabilitation counselling among women in Mkushi District and to suggest measures on how to make Depression Rehabilitation Counselling services easier to access.

5.1 Causes of Depression among Women

A lot of things have been known to increase the chances of depression prevalence. According to (Schimelpfening, 2020), there are varied causes of depression which fall into categories such as biological factors, environmental factors, social factors and lifestyle factors. This is supported by the findings of the study whose list of causes falls under these categories too.

From the study, some biological factors that came up were infertility and chronic illness such as HIV and Cancer. In line with this, Hapunda et. al., (2015) found that patients with illnesses such as diabetes usually had depression. HIV is one of, if not the most common chronic illnesses and Wong et. al. (2017) found that depression was prevalent in ... women who were HIV positive in South Africa. McKee and Kelly (2020) found similarly that advanced disease can be oppressive and can cause intense emotional suffering. Chronic illness (such as HIV, Diabetes and Cancer), is a long and lonely journey that causes people to have extreme sadness and lose interest in life as they lose hope about living normal lives again. It is therefore not surprising that people with chronic illnesses struggle with depression.

For environmental factors, the study found that marital problems, infidelity, gender based violence, verbal and emotional abuse. In agreement with this, Paulson (2020) found that there was a strong correlation between intimate partner violence and depression. Khan and Khan

(2012) also were in agreement in the findings which stated that issues with relationships with significant others and childhood traumatic experiences caused depression. Mapayi (2013) supported the assertion on gender violence being a cause of depression in their study findings. A woman in an abusive relationship will struggle with maladaptive behaviour such is alcoholism, will struggle with self-esteem issues and poor decision-making. She needs rehabilitation counselling to help her identify and challenge her negative beliefs as well as the source of those beliefs. Counselling could also help her to replace the negative belief with a positive one that empowers her to believe in herself and want better for herself. This is the basis for cognitive behavioural theory which posits that dysfunctional behaviour is brought about by dysfunctional thinking, that thinking is shaped by one's beliefs, and that one's beliefs decide the course of their actions.

When a marriage partner is neglectful, abusive, or unfaithful, staying with them in that abusive relationship can have long-lasting effects including depression. Findings of a study by Maystone et. al., (2020), concluded that depression has roots in social adversity, predominantly economic and relationship problems, substantiating the findings of this study which indicate that emotional and verbal abuse, marriage problems, infidelity, etc., are all cases of depression in women. Experiences of abuse of any kind, physical, emotional, verbal, affect how one feels about themselves and they relate to others. Women who have been abused have a higher risk of developing depression. Over time, emotional and verbal abuse can contribute to low sense of self-worth, feelings of worthlessness and a desire to commit suicide.

Using cognitive behavioural therapy, rehabilitation counselling would work here to help a client recognise where these negative thoughts emanate from, empower the client to see themselves through the perspective that they have untold value and deserve to be treated with love and respect. This is what was lacking in the study as findings show that most women did not receive any rehabilitation counselling at all.

The social issues this study found were stigma, widowhood/loss and grief, low achievement/personal failure and worry for the future. In line with this, Bhattacharya et. al. (2018) found in their study, that interpersonal conflict, widowhood and carrying the greater burden of caregiving led to women developing depression. Harrington et. al. (2021) found similarly that HIV-associated stigma was commonly identified as a cause of depression. Conflict

in relationships, grief from loss of someone significant and stigma that emanates from an HIV positive status are all potent causes of deep sadness, anxiety, sleep deprivation, poor concentration, loss of interest in life and dysfunctionality in life at home, at work, at school, etc. These all affect quality of life and cannot just go away on their own, necessitating rehabilitation counselling.

Lifestyle factors identified in the study were educational uncertainty, unemployment and financial insecurity. In line with this, Bhattacharya et. al. (2018) identified financial insecurity as a cause of depression. This could be because financial insecurity affects the ability of the woman to care for her family by providing food, shelter, clothing, education and health care. Inability to meet these needs causes the person to worry, have anxiety, insomnia/sleep deprivation, deep sadness, a low sense of self, etc., again necessitating the need for rehabilitation counselling.

By virtue of these varied causes of depression found in this study, rehabilitation counselling interventions would also inevitably need to be problem-specific. The counsellor would need to be flexible and research extensively to help create an intervention that is uniquely relevant and effective for each the clients' unique conditions.

5.2 Experiences of Rehabilitation Counselling for Women

In this study, findings show that there are very few experiences of rehabilitation counselling among women. One of the reasons given had to do with the fact that depression is a “secret illness” not to be shared for fear of what others might say. This is in line with Harrington et. al., (2021)'s findings and Wong et. al.'s (2017) findings that HIV-associated stigma was commonly identified as a cause of depression.

The general public tends to give negative labels to people who experience mental illness such as depression because mental illness is so little understood. These labels are a big deterrent to those seeking treatment which is why most people with depression are hesitant to talk about their condition. Lucas et. al., (2019)'s findings are in line with this. Their findings show that because of fear of being judged, marginalised and excluded, women would rather not disclose anything about their depression. Women would rather not disclose their condition in the interest of self-preservation. This means they also do not get assessed, diagnosed, let alone treated. The result is a low quality of life characterised by deep sadness and dysfunctionality. Sometimes this becomes

too much to handle that they resort to coping strategies such as alcohol abuse, and in unfortunate cases, to suicide.

Sometimes women do not disclose their condition because depression is viewed as laziness or a weakness and a taboo for a woman to experience. But depression is an illness not a weakness and certainly not a taboo (The Guardian, 2021), and people would do well to begin to see it that way. There has to be some form of affirmative action to debunk the myths surrounding depression (and general mental health), and replace them with facts that people can accept and internalise and begin to live as they seek help for their depression (and other mental illnesses). One way to do this would be to sensitize communities about depression; what it is, its causes, its symptoms and its treatment. This can be done at primary care level which is where most go to seek health care.

5.3 Hindrances to Rehabilitation Counselling for Women

The findings of this study indicated that women did not even know that they had a condition, or that their condition was depression, and that they did not really know much about depression, that depression can be treated, where it can be treated from and by whom. This aligns with the study by Lucas et. al. (2019) whose findings were that women were unable to express themselves, could not recognise their feelings as problems of mental health but related them to living through difficult life circumstances, resulting in their depression being undiagnosed and untreated.

Depression can and does easily go undiagnosed. At primary care level, detection of depression is a very important step in the provision of effective care. Detection is very low though, and contributes to why only very few people have experiences of treatment. But even if depression was detected, the lines of treatment are blurry because there is little to no information about how to access care, and more importantly, there are no counsellors at most primary care facilities. In fact, there is just not much information at primary health care level that tells people about depression and what to do about it.

Despite this lack of information, the burden of untreated depression in Zambia cannot be ignored. The WHO (2017) puts things into perspective by reporting that at least 4 percent of the population of Zambia struggles with depressive disorders. These statistics show clearly that

depression is present in the country, but that is where this information ends. Beyond that, there is a lack of information on how this depression is addressed. The survey by Nyamukoho, et. al. (2019) mentioned earlier in literature revealed that using non-professionals who are trained to screen and identify those with depression during pregnancy and provide evidence based care management could considerably reduce the treatment gap for depression in pregnancy for example. This is an approach that looks to the community for solutions. A community based approach like this, that draws in stakeholders from all levels of the community is necessary. These stakeholders would need to constitute people with depression, their families, community leaders, government leaders, education and health service providers, non-governmental organisations, human rights activists, mental health activist and donor agencies. This is supported by a sentiment a respondent in the study by Munakampe (2020) gave about the training of mental health assistants, *if the same people in the community were able to be trained and then share the knowledge with the rest of the community, I think that would be very useful.*

Concerted effort by community stakeholders needs to be mobilised to disseminate information and raise awareness about depression, perhaps even identify people struggling with depression, train some lay counsellors for depression, refer severe cases to higher mental health institutions, fund the training of mental health careers at tertiary levels and beyond, create policies, implement legal frameworks governing mental health, provide medication and the building or rehabilitation of mental health infrastructure. All this looks and sound insurmountable but when allocated to different stakeholders, and with detailed planning and implementation, it can be done.

5.4 Measures to Make Access to Rehabilitation Counselling Services Easy for Women

Hindrances to rehabilitation counselling for women beg the question, what then could be measures to make access to rehabilitation counselling services easy for women? This study showed that there are women in Mkushi with depression but there is no more information further than that. There is no information about their treatment, there is no reference material anywhere that they could have referred to for information on what their illness entailed, who they could see for treatment, when, etc. There is just no easy way to understand the system within which they could seek help. Since the majority of people who seek help for any mental health conditions do so at primary care level, the above deficits in primary care must be addressed.

Findings of this study show that some key areas where depression management is needed are patient education on the understanding of depression, improved screening and diagnosis, its treatment options, and improving primary care workers' attitudes. Ngocho et. al. (2019) support this in their study when they assert that screening for depression was important, for example, in the successful prevention of mother to child transmission (PMTCT) of HIV. Screening is important because it leads to identification of women with depression so that they can be followed up to be given the right treatment. It is also important because it can help in the determination of treatment options. In fact, early identification and treatment prevents or lessens long term illness or years of suffering.

Depression, despite being widely prevalent, is little known. Findings of the study show that women had no vital information about what depression is; its causes, symptoms and treatment options. Clearly, there is an information gap between knowledge pertaining to depression and the clients/patients of depression. So far information out there is scholarly or academic, in books and articles and the internet, and not really targeted at the communities where the common man/woman lives. Again drawing from the sentiments of the respondents, there is no 'easy to comprehend' information about screening and diagnosis, causes and symptoms or treatment options for depression. There is nothing to address the stigma and resulting fear to talk about it with someone or to seek treatment as the case may be.

But an advertising campaign can be carried out to create awareness about depression so that people are knowledgeable about the condition and to receive help for it. A study whose objective was to develop a rigorous marketing strategy for engaging at-risk individuals with an internet-based depression prevention intervention in primary care was carried out by Voorhees et.al (2010). It targeted key attitudes and beliefs about depression. The study found that marketing strategies for preventive and curative interventions for depression can be developed and successfully introduced and marketed in primary care. Specifically, this study found that this marketing resulted in increased use of evidence-based treatments by clinicians, and reduced stigma by consumers and the population in general, and increased medication use for depression... (Voorhees et. al., 2010). This shows that what is needed to bridge the information gap between people with depression and vital information about depression, is marketing/advertising/sensitization. Sensitization can take many forms such as posters,

community and national radio and television broadcasts, periodic classes (e.g., weekly), awareness campaigns, etc. Sensitization could target one aspect at a time, such as symptoms, or causes, or treatment, or it could target all of them at the same time. The main objective would be to make sure women (and men) have information ready about all aspects of depression especially how and where to seek treatment. This would ensure that no cases go undiagnosed or untreated, and that no unnecessary suffering is prevalent. This can be planned for and implemented at primary care level to maximise the number of people actually learning about and seeking out rehabilitation counselling for depression from their local primary care centres.

5.5 Summary of Chapter

This study sought to explore the experiences of rehabilitation counselling by women with depression in Mkushi district of Zambia. Most women had no experiences of rehabilitation counselling because they did not have knowledge and/or information about what depression is; its causes, symptoms, treatment and where to go for treatment. Sensitization would go a long way in bridging the information gap between people with depression and the treatment of depression. This would in turn ensure that no depression cases go untreated or undiagnosed.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.0 Overview

This chapter presents the conclusion and recommendations of this study whose purpose was to explore the experiences rehabilitation counselling by women with depression in Mkushi.

6.1 Conclusion

Based on findings of this study, it can be concluded that there are varied causes of depression among women in Mkushi. This means their experiences of rehabilitation would need to vary as each intervention would be tailored toward the specific experiences of each person. It can also be concluded that since most women in the study did not experience any rehabilitation because of a lack of knowledge about depression (causes, symptoms, treatment) and stigmatization there has to be a reorientation of how this service is delivered so that women can begin to receive help for the depression. This re-orientation hinges on provision of information pertinent to depression such as what is it, its symptoms, its causes, how it is treated, where it is treated and by whom at primary care level through sensitization programmes. This kind of information dissemination will demystify it and encourage people with depression to seek rehabilitation counselling. Primary health care workers play an important role in the management of depression. There is need for rehabilitation counselling at primary care level therefore, because that is where the majority of people in Mkushi seek health care from. This implies that there is need for a multi professional team to include skills in proper screening and/or assessment, diagnosis and treatment of depression (and mental health conditions).

6.2 Recommendations

Based on findings of this study, the following recommendations can be made:

1. Each hospital administration could introduce multi professional teams at primary care level that can work alongside clinicians to screen and assess/diagnose depression aimed at reducing the prevalence of undiagnosed depression in the communities.
2. Each hospital could combine already existing, already funded programmes such as cervical cancer, ART, Antenatal and Postnatal/Under five clinics, Victim Support Unit, with depression screening and treatment (rehabilitation counselling) because women here already struggle with depression.
3. Each teaching hospital and health training institutes could revise the training of personnel of already existing and already funded programmes, (for example, the training of cancer

care specialists, HIV care specialists) to integrate screening and rehabilitation counselling for depression.

6.3 Future Research

For future research, the following can be areas:

1. Provision of rehabilitation counselling services to women at primary care level
2. Provision of rehabilitation counselling services to men at primary care level.
3. Integration of depression rehabilitation counselling in already existing and already funded lay counselling programmes for HIV and Cervical cancer as clients here usually struggle with depression.

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APPENDIX I: INTERVIEW GUIDE

Dear respondent,

I am a post graduate student carrying out interviews on an academic study called REHABILITATION COUNSELLING FOR DEPRESSION: EXPERIENCES OF WOMEN IN MKUSHI. This study is carried out in partial fulfilment of the requirements for a Master of Science in Counselling at the University of Zambia in corroboration with the Zimbabwe Open University. Your participation is very important as it will help to gather important information that will greatly help women struggling with Depression. All the information given will be treated with the strictest confidentiality and anonymity and will be used only for this study. Thank you so much for your help.

INTERVIEW GUIDE ON EXPERIENCES OF WOMEN WITH DEPRESSION

a. Personal Information

1. Age
2. Education

b. Questions relating to causes of depression among women in Mkushi District

3. What are the main causes of depression among women in Mkushi District?
4. Looking back on your life, can you remember some issues or events that have caused you to feel the way you do?

c. Questions relating to experiences of women in Mkushi in terms of how Rehabilitation Counselling helped women who had depression?

5. What are the experiences of women in Mkushi in terms of how Rehabilitation Counselling helped women who had depression?
6. What are your experiences of how Rehabilitation Counselling helped you with your depression?
7. Can you describe to me how you were treated for your depression, where and by whom?

8. Would you say that was sufficient for what you were experiencing? Please give reasons for your answer.
9. What kind of treatment or help do you feel would benefit you or would have benefited you the most?

d. Questions relating to hindrances if any, to accessing depression rehabilitation counselling among women in Mkushi District?

10. What would you say are hindrances, if any, to accessing depression rehabilitation counselling among women in Mkushi District?

e. Questions relating to measures could make accessing Rehabilitation Counselling services easier for women in Mkushi District?

11. What measures could make accessing Rehabilitation Counselling services easier for women in Mkushi District?
12. What do you think can make or would have made getting treatment easier for you personally for your depression?
13. What do you think can make or would have made getting treatment harder for you personally for your depression?